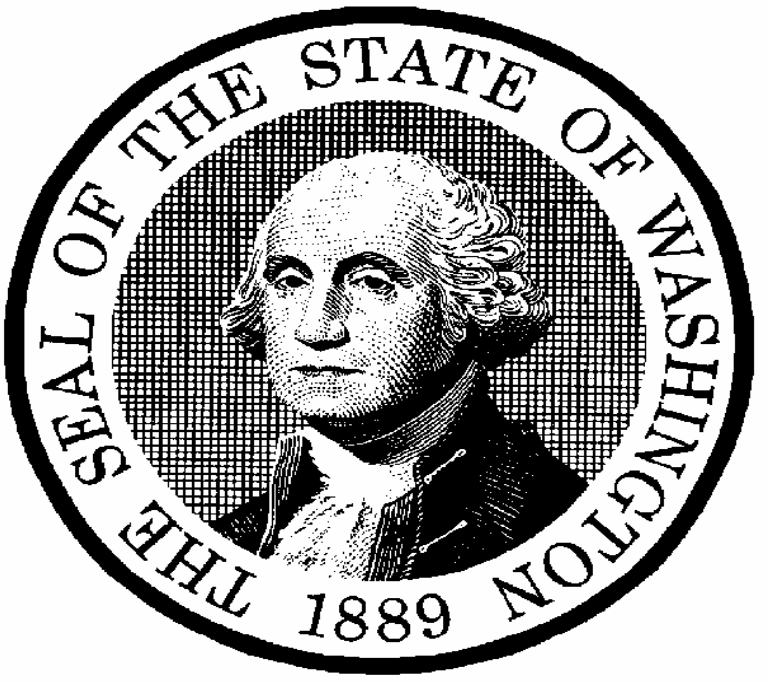
Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

Medical Assistance Administration



Planned Home Births and Births in Birthing Centers

Billing Instructions

WAC 388-533-400 & 600

January 2005

About this publication

This publication supersedes previous Planned Home Births Billing Instructions and Births in Birthing Centers Billing Instructions, and Numbered Memoranda 03-95MAA, 04-40MAA, 04-73MAA, and 04-106MAA.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
January 2005

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Important Contacts

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of the inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. [WAC 388-502-0020(2)].

Where can I get information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Provider Enrollment:
(866) 545-0544 (toll free)
http://maa.dshs.wa.gov/provrel

To become a home birth provider you must send in documentation of requirements listed on page A.2 to the Planned Home Births and Births in Birthing Centers Program Manager (see below).

Where do I write/call if I have policy questions or Exception to Rule questions?

Planned Home Births and Births in Birthing Centers Program Manager
Division of Medical Management
Program Mgmt & Authorization Section
PO Box 45506
Olympia, WA 98504-5506
FAX (360) 586-1471

Where do I send my claims?

Electronic Claims:
Providers who would like to access the *free* WAMedWeb application can enroll now by contacting ACS EDI Gateway via telephone at (800) 833-2051 (toll free) or visit
https://wamedweb.acs-inc.com/wa/general/home.do

Hard copy claims:
Division of Program Support
PO Box 9247
Olympia, WA 98507-9247

Where can I find MAA's billing instructions and numbered memoranda?

To view and download, visit MAA's website:
http://maa.dshs.wa.gov
Click on *Billing Instructions/Numbered Memoranda*

To have a hard copy sent to you, visit the Dept of Printing's web site:
http://www.prt.wa.gov/ Click on *General Store*

Where do I call/look if I have questions regarding…

Billing for planned home births and births in birthing centers or for facility billings?
Provider Relations Unit
(800) 562-6188 (toll free)
http://maa.dshs.wa.gov/provrel

Where do I call/look if I have questions regarding…

Electronic Billing?
Electronic Media Claims Help Desk
(360) 725-1267

Newborn Screenings?
Department of Health
(206) 361-2890 or 1-866-660-9050
Email: nbs.prog@doh.wa.gov

Medical Information?
University of Washington Med Con Line
(800) 326-5300 (toll free)

Maternity Support Services/ Infant Case Management?
http://maa.dshs.wa.gov/ click on *First Steps*
MAA Family Services Section
(360) 725-1655
Email: Firststeps@dshs.wa.gov

Private insurance or third party liability, other than MAA managed care?
Coordination of Benefits Section
(800) 562-6136 (toll free)
http://maa.dshs.wa.gov/LTPR

Change in the MAA managed care plan?
(800) 562-3022 (toll free)

Which Birthing Centers are MAA-Approved Birthing Centers?

- Bellingham Birthing Center – Bellingham, WA
- Best Beginnings Birth Center-Lynnwood, WA
- Birthing Inn -Tacoma, WA
- Birthright LLC-Spokane, WA
- Cascade Birth Center-Everett, WA
- Columbia Birth Center, Kennewick, WA
- Community Birth and Family Center-Seattle, WA
- Eastside Birth Center-Bellevue, WA
- Greenbank Women's Clinic and Childbirth Center-Greenbank, WA
- Lakeside Birth Center-Sumner, WA
- Puget Sound Birth Center-Kirkland, WA
- Seattle Home Maternity Services and Childbirth Center-Seattle, WA
- Seattle Naturopathy Acupuncture, and Childbirth Center-Seattle, WA
- Wenatchee Midwife and Childbirth Center-Wenatchee, WA

Definitions

This section defines terms and acronyms used in these billing instructions.

Authorization Number – A 9-digit number assigned by MAA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Authorization – MAA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Birthing Center – A specialized facility licensed as a childbirth center by the Department of Health (DOH) under chapter 246-349 WAC. [WAC 388-533-0400(1)(a)].

Birthing Center Provider – Any of the following individuals, who have a Core Provider Agreement with the Medical Assistance Administration (MAA) to deliver babies in a birthing center:

- A midwife, currently licensed in the State of Washington under chapter 18.50 RCW;
- Nurse Midwife currently licensed in the State of Washington under chapter 18.79 RCW; or
- Physician licensed in the State of Washington under chapter 18.57 or 18.71 RCW.

Bundled services – Services integral to the major procedure that are included in the fee for the major procedure. For the Planned Home Birth and Births in Birthing Centers program, certain services which are customarily bundled must be billed separately (unbundled) when the services are provided by different providers. [Refer to WAC 388-533-0400(1)(b)].

Chart - A compilation of medical records on an individual patient.

Client – An applicant for, or recipient of, DSHS medical care programs.

Community Services Office (CSO) - An office of the department which administers social and health services at the community level. [WAC 388-500-0005]

Consultation – The process whereby the provider, who maintains primary management responsibility for the woman's care, seeks the advice or opinion of a physician (MD/DO) on clinical issues that are patient-specific. These discussions may occur in person, by electronic communication, or by telephone.

Continued on next page…

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A consulting relationship may result in:

- Telephone, written or electronic mail recommendations by the consulting physician;
- Co-management of the patient by the birthing center provider and the consulting physician;
- Referral of the patient to the consulting physician for examination and/or treatment; or
- Transfer of patient's care from the birthing center or home birth provider to the consulting physician.

Core Provider Agreement – Is the basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Current Procedural Terminology (CPT)® – A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association.

Department – The state Department of Social and Health Services.
[WAC 388-500-0005]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Facility fee – The portion of MAA's payment for the hospital or birthing center charges. This does not include MAA's payment for the professional fee.
[Refer to WAC 388-533-0400(1)(c)]

Global fee – The fee MAA pays for total obstetrical care. Total obstetrical care includes all bundled antepartum care, delivery services, and postpartum care.
[Refer to WAC 388-533-0400(1)(d)].

High-risk pregnancy – Any pregnancy that poses a significant risk of a poor birth outcome.
[Refer to WAC 388-533-0400(1)(e)].

Home birth kit – Disposable supplies that are used in a planned home birth. *(See list of supplies required on page A.3.)*

Home Birth Provider -

- A midwife currently licensed in the State of Washington under chapter 18.50 RCW; or
- Nurse-midwife currently licensed in the State of Washington under chapter 18.79; or
- Physician licensed in the State of Washington under chapter 18.57 or 18.71,

who has qualified to become a home birth provider who will deliver babies in a home setting, and has signed a core provider agreement with the Medical Assistance Administration.

Internal Control Number (ICN) - A 17-digit number that appears on the Remittance and Status Report by the client's name. Each claim is assigned an ICN when it is received by MAA. The number identifies that claim throughout the claim's history.

Managed care - A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[Refer to WAC 388-538-0500]

Maximum allowable fee – The maximum dollar amount that MAA reimburses a provider for specific services, supplies, and equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (SCHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Identification (ID) Card – The form DSHS uses to identify clients of medical programs. These cards are good only for the dates printed on them. Clients will receive a Medical ID card in the mail each month they are eligible. These cards were formerly called medical coupons or MAID cards.

Medically necessary - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section 'course of treatment' may include mere observation or, where appropriate, no treatment at all.
[WAC 388-500-0005]

Midwife – An individual possessing a valid, current license to practice midwifery in the State of Washington as provided in chapter 18.50 RCW, chapter 246-834 WAC, or an individual recognized by the Washington Nursing Care Quality Assurance Commission as a certified nurse midwife as provided in chapter 18.79 RCW, chapter 246-839 WAC. [WAC 246-329-010)]

Patient Identification Code (PIC) - An alphanumeric code assigned to each Medical Assistance client consisting of the patient's:

a) First and middle initials (*or* a dash (-) if the middle initial is not indicated);
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY);
c) First five letters of the last name; and
d) Alpha or numeric character (tiebreaker).

Planned home birth – A natural birth that takes place in a home setting and is assisted by a qualified licensed midwife, certified nurse midwife who is licensed as an ARNP, or a physician.

Professional Fee – The portion of MAA's payment for services that rely on the provider's professional skill or training, or the part of the reimbursement that recognizes the provider's cognitive skill. [Refer to WAC 388-533-0400(1)(f)]

Provider – An institution, agency, or person:

- Who has a signed agreement with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Record - Dated reports supporting claims submitted to the Washington Medical Assistance Administration for medical services provided in an office, nursing facility, hospital, outpatient, emergency room, or other place of service.

Referral – The process by which the provider directs the client to a physician (*MD/DO*) for management (examination and/or treatment) of a particular problem or aspect of the client's care.

Remittance and Status Report (RA) - A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party – Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005].

Usual and Customary Fee – The rate that may be billed to the Department for a certain service or equipment. This rate may not exceed:

- The usual and customary charge billed to the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

About the Program

What is the goal of the program?

The goal of the Planned Home Births and Births in Birthing Centers Program is to provide a safe alternative delivery setting to pregnant Medical Assistance clients who are at **low-risk** for adverse birth outcomes. This program promotes access to care by allowing low-risk women to give birth in an out-of-hospital setting.

When does MAA cover planned home births and births in birthing centers? [Refer to WAC 388-533-0600(1)]

MAA covers planned home births and births in birthing centers for its clients when the client and the maternity care provider choose to have a home birth or to give birth in an MAA-approved birthing center and the client:

- Is eligible for CN or MN scope of care (see Client Eligibility section, page B.1);
- Has an MAA-approved home birth provider who has accepted responsibility for the planned home birth or a provider who has accepted responsibility for a birth in an MAA-approved birthing center;
- Is expected to deliver the child vaginally and without complication (i.e., with a low risk of adverse birth outcome); and
- Passes MAA's risk screening criteria. (For risk screening criteria, see page C.2).

What are the requirements to be an MAA-approved birthing center facility? [Refer to WAC 388-533-0600(3)]

An MAA-approved birthing center facility must:

- Be licensed as a childbirth center by the Department of Health (DOH) under chapter 246-349 WAC;
- Be specifically approved by MAA to provide birthing center services (see the Important Contacts section for a list of approved centers);
- Have a valid Core Provider Agreement with MAA; and
- Maintain standards of care required by DOH for licensure.

MAA suspends or terminates the core provider agreement of a birthing center if it fails to maintain DOH standards.

What are the requirements to be an MAA-approved planned home birth provider or birthing center provider?

[Refer to WAC 388-533-0600(2),(5), and (6)]

MAA-approved planned home birth providers and birthing center providers must:

- Have a Core Provider Agreement with MAA;
- Be licensed in the State of Washington as a:
  - ✓ Midwife under chapter 18.50 RCW; or
  - ✓ Nurse midwife under chapter 18.79 RCW; or
  - ✓ Physician under chapter 18.57 or 18.71 RCW; and
- Have evidence of current cardiopulmonary resuscitation (CPR) training for:
  - ✓ Adult CPR; and
  - ✓ Neonatal resuscitation.
- Have current, written, and appropriate plans for consultation, emergency transfer, and transport of client and/or newborn to a hospital;
- Obtain from the client a signed Informed Consent, including the criteria listed on page D.13, in advance of the birth.
- Follow MAA's Risk Screening Guidelines (page C.2) and consult with and/or refer the client or newborn to a physician or hospital when medically appropriate;
- Make appropriate referral of the newborn for pediatric care and medically necessary follow-up care; and
- Inform parents of the benefits of a newborn screening test and offer to send the newborn's blood sample to DOH for testing (the parent may refuse this service). The provider must pay DOH for the cost of the tests and then bill MAA for reimbursement.

In addition, MAA-approved home birth providers must…

In addition, MAA-approved home birth providers must send the following documentation to the Planned Home Birth and Birthing Center Program Manager (see *Important Contacts* section):

- Provide medically necessary equipment, supplies, and medications for each client (see list on page A.3 for home birth supplies);

- Have arrangements for 24 hour-per-day coverage;
- Have documentation of contact with local area emergency medical services to determine the level of response capability in the area; and
- Participate in a formal, state sanctioned, quality assurance/improvement program or professional liability review process (e.g., programs offered by Joint Underwriting Association (JUA), Midwives' Association of Washington State (MAWS), etc.).

What equipment, supplies, and medications are required for a planned home birth?

Equipment:

Oxygen tank with tubing and flow meter
Neonatal resuscitation mask and bag
Adult mask and oral airway
Fetoscope and/or Doppler device (with extra batteries if only Doppler)
Stethoscope and sphygmomanometer
Thermometer
Portable light source
Sterile birth instruments
Sterile instruments for episiotomy and repair
Tape measure
Portable oral suction device for infant

Medications:

Pitocin, 10 U/ml
Methergine, 0.2 mg/ml
Epinephrine, 1:1000
MgSO4, 50% solution, minimum 2-each of 5 gms in 10 cc vials
Local anesthetic for perineal repair
Vitamin K, neonatal dosage (1 mg/0.5 ml)
Neonatal ophthalmic ointment (or other approved eye prophylaxis)
IV fluids, one or more liters of LR

Supplies:

IV set-up supplies
Venipuncture supplies
Urinalysis supplies - clean catch cups and dipsticks
Injection supplies suitable for maternal needs
Injection supplies suitable for neonatal needs
Clean gloves
Sterile gloves: pairs and/or singles in appropriate size
Sterile urinary catheters
Sterile infant bulb syringe
Time piece with second hand
Sterile cord clamps, binding equipment or umbilical tape
Antimicrobial solution(s) for cleaning exam room and client bathroom
Antimicrobial solution(s)/brush for hand-cleaning
Sterile amniohooks or similar devices
Cord blood collection supplies
Appropriate device for measuring newborn's blood sugar values
Suture supplies
Sharps disposal container, and means of storage and disposal of sharps
Means of disposal of placenta

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Client Eligibility

Who is eligible for full-scope maternity care and newborn delivery services? [Refer to WAC 388-533-0400(2)]

MAA covers full-scope maternity care and newborn delivery services to fee-for-service clients who present a current Medical Identification Card with one of the following identifiers:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP-CHIP	CNP-Children's Health Insurance Program
LCP-MNP	Limited Casualty Program – Medically Needy Program

☞ **Note**: If the client is pregnant but her DSHS Medical ID Card does not list one of the above medical program identifiers, please refer the client to her local Community Services Office (CSO) to be evaluated for a possible change in her Medical Assistance program that would enable her to receive full-scope maternity care.

MAA Managed Care Clients

[Refer to WAC 388-533-0400(2)]

- Clients enrolled in an MAA managed care plan will have a plan indicator in the HMO column on their DSHS Medical ID Card. The managed care plan's toll free number is located on the Medical ID Card.

- Managed care enrollees must have all services arranged and provided by their primary care providers (PCP), except in the area of women's health care services. For certain services, such as maternity and gynecological care, women may go directly to a specialist in women's health without a referral from her PCP. However, the provider **must be within** her managed care plan's provider network.

- Please contact the managed care plan and the PCP for additional information on providers, including participating hospitals and birthing facilities.

- If the client's obstetrical provider is not contracted with the client's managed care plan, the provider will not be reimbursed for services unless a referral is obtained from the plan. The client needs to call her plan for assistance if she has questions. For further information and/or to request an exemption, the client may call the Exception Case Management Section at 1-800-794-4360, Monday through Friday 8:00am to 4:30pm, except holidays. Providers cannot request exemptions for clients.

☞ **Note:** Primary Care Case Management (PCCM) clients will have the **PCCM** identifier in the HMO column on their DSHS Medical ID Cards. **Please make sure these clients have been referred by their PCCM prior to receiving services**. The Woman's Direct Access health care law does not apply to PCCM clients. The referral number is required on the HCFA-1500 claim form. (See page D.12, How do I bill for services provided to PCCM clients.)

To prevent billing denials, ALWAYS check the client's DSHS Medical ID Card prior to scheduling services and at the time of the service. This is to make sure proper authorization or referral is obtained from the primary care provider and/or plan.

First Steps Program Services

All pregnant women receiving Medical Assistance qualify for First Steps. First Steps is a program that helps low-income pregnant women get the health and social services they may need. These services help healthy mothers have healthy babies and are available as soon as a client knows she is pregnant. First Steps services are supplemental services that include: Maternity Support Services (MSS), Child Birth Education, First Steps Childcare, and Infant Case Management (ICM).

Maternity Support Services (MSS)/Infant Case Management (ICM)

Maternity Support Services (MSS) are preventive health services for clients to have healthy pregnancies. Services include an assessment, education, intervention, and counseling. A team of community health nurses, nutritionists, behavioral health specialists and, in some agencies, community health workers provide the services. The intent is to provide MSS as soon as possible in order to promote positive birth and parenting outcomes.

Pregnant women with First Steps coverage can receive Maternity Support Services during pregnancy and through the end of the second month following the end of the pregnancy. MSS can begin during the prenatal, delivery, or postpartum period.

Sometimes there are family situations that place infants at higher risk of having problems. Infant Case Management that starts in the baby's third month (after Maternity Support Services conclude) can help a client learn to use the resources in her community so that the baby and family can thrive. Infant case management may start at any time during the child's first year. It continues through the month of the infant's first birthday.

For further information on the MSS/ICM program, visit the First Steps web site at: http://maa.dshs.wa.gov/firststeps/.

Childbirth Education

Childbirth education classes are available to all Medicaid eligible women. Instruction takes place in a group setting and may be completed over several sessions. Childbirth education is intended to help the client and her support person(s) to understand the changes the client is experiencing, what to anticipate prior to and during labor and delivery, and to help develop positive parenting skills. For further information on Childbirth Education, visit the First Steps web site at: http://maa.dshs.wa.gov/firststeps/ . The Childbirth Education Consultant can be reached by calling (360) 236-3552.

First Steps Childcare

A client may be screened and receive authorization for First Steps Childcare for a client's child(ren) during the client's pregnancy or postpregnancy period when the client pursues any of the following covered services for herself or her newborn child(ren):

- Childbirth education classes;
- Delivery/birth
- Dental care;
- Hospital procedures;
- Laboratory tests;

Continued on next page…

Continued from previous page…

- Infant Case Management (ICM) visits;
- Maternity Support Services (MSS) visits, including nursing, behavioral health, nutrition, and Community Health worker visits; and
- Medical visits.

For further information on the First Steps Childcare program, visit the First Steps web site at: http://maa.dshs.wa.gov/firststeps/.

First Steps Childcare state staff can be reached by calling: 1-888-889-7514.

For more information about First Steps services and/or to receive a list of contracted providers, please contact the First Steps Clearinghouse at (360) 725-1666 or the First Steps website at: http://maa.dshs.wa.gov/firststeps.

Prenatal Management/ Risk Screening Guidelines

Prenatal Management

[WAC 388-533-0600(1)(d)]

- Providers must screen their clients for high-risk factors.
- The provider must consult with consulting physicians when appropriate. Follow MAA's Risk Screening Guidelines and Indications for Consultation and Referral.
- **To be reimbursed for CPT codes 99211 through 99215 with HCPCS modifier TH (Increased Monitoring Prenatal Management),** the client's record must contain the required documentation as listed below.

The diagnoses listed below are suitable for management by the midwife, but do require more visits to monitor the client. Documentation of more visits is required in the client's chart.

Diagnosis Code	Condition
640.03	Threatened abortion *(first trimester).* *(May be managed by the midwife without consultation with a physician.)*
643.03	Mild hyperemesis gravidarum (*May be managed by the midwife and will require more visits to monitor the client.)*
648.83	Abnormal glucose tolerance in a gestational diabetic *(If the condition is responsive to treatment (i.e., controlled by diet alone.)*

See next page for more…

The diagnoses listed below are suitable for prenatal co-management by a home birth or birthing center provider and a consulting physician. If a physician is the provider, that physician should consult with another physician as needed. These diagnoses require more frequent monitoring and MAA allows additional payment(s) to the provider. (See page D.5 for further information.) **The client's record must contain either documented consultation or actual evaluation by a consulting physician in order for the provider to be reimbursed for the following diagnosis codes:**

Diagnosis Code	Condition
642.03	Benign essential hypertension complicating pregnancy, childbirth, puerperium (controlled without medication)
642.33	Transient hypertension of pregnancy
644.03	Threatened premature labor *(after consultation and/or referral to a physician, and the midwife and physician have determined the client is stable and appropriate for close monitoring by the midwife)*
648.23	Anemia *(Hct<30 or Hgb<10) – Unresponsive to treatment*

Risk Screening Guidelines

[Refer to WAC 388-533-0600(7)]

MAA does not cover planned home births or births in birthing centers for women identified with any of the following conditions:

- ✓ Previous cesarean section;
- ✓ Current alcohol and/or drug addiction or abuse;
- ✓ Significant hematological disorders/coagulopathies;
- ✓ History of deep venous thrombosis or pulmonary embolism;
- ✓ Cardiovascular disease causing functional impairment;
- ✓ Chronic hypertension;
- ✓ Significant endocrine disorders including pre-existing diabetes (type I or type II);
- ✓ Hepatic disorders including uncontrolled intrahepatic cholestasis of pregnancy and/or abnormal liver function tests;
- ✓ Isoimmunization, including evidence of Rh sensitization/platelet sensitization;
- ✓ Neurologic disorders or active seizure disorders;
- ✓ Pulmonary disease;
- ✓ Renal disease;
- ✓ Collagen-vascular diseases;
- ✓ Current severe psychiatric illness;
- ✓ Cancer affecting site of delivery;
- ✓ Known multiple gestation;
- ✓ Known breech presentation in labor with delivery not imminent; or
- ✓ Other significant deviations from normal as assessed by the provider.

Smoking Cessation for Pregnant Women

[Refer to WAC 388-533-0400(20)]

MAA reimburses providers for smoking cessation counseling as part of an antepartum care visit or a post-pregnancy office visit for tobacco dependent eligible pregnant women.

What is Smoking Cessation Counseling?

Smoking cessation counseling consists of provider information and assistance to help the client stop smoking. Smoking cessation counseling includes the following steps:

- Step 1: Asking the client about her smoking status;
- Step 2: Advising the client to stop smoking;
- Step 3: Assessing the client's willingness to set a quit date;
- Step 4: Assisting the client to stop smoking, which includes a written quit plan. If the provider considers it appropriate for the client, the "assisting" step may also include prescribing smoking cessation pharmacotherapy, as needed (see next page); and
- Step 5: Arranging to track the progress of the client's attempt to stop smoking.

Who is eligible for smoking cessation counseling?

Fee-for-service: Tobacco dependent, pregnant women covered under fee-for-service are eligible for smoking cessation counseling.

Managed Care: Tobacco dependent, pregnant women who are enrolled in a managed care plan must have services arranged and referred by their primary care provider (PCP). Clients covered under a managed care plan will have a plan indicator in the HMO column on their Medical Identification card. **Do not bill MAA for Smoking Cessation Counseling as it is included in the managed care plans' reimbursement rates.**

Who is eligible to be reimbursed for smoking cessation counseling?

MAA will reimburse only the following providers for smoking cessation counseling as part of an antepartum care visit or a post-pregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination):

- Physicians;
- Physician Assistants (PA) working under the guidance and billing under the provider number of a physician;
- Advanced Registered Nurse Practitioners (ARNP); and
- Licensed Midwives (LM), including certified nurse midwives (CNM).

What is covered?

MAA allows one smoking cessation counseling session per client, per day, up to 10 sessions per client, per pregnancy. The provider must keep written documentation in the client's file for each session. The documentation must reflect the information listed on the following page.

MAA covers two levels of counseling:

- Basic counseling (approximately 15 minutes) which includes Steps 1-3 on previous page; and
- Intensive counseling (approximately 30 minutes) which includes Steps 1-5 on previous page.

Use the most appropriate procedure code from the following chart when billing for smoking cessation:

CPT Procedure Code	Brief Description	Restricted to Diagnoses:
99401	Preventive counseling, indiv [approximately 15 minutes]	648.43 (antepartum) 648.44 (postpartum)
99402	Preventive counseling, indiv [approximately 30 minutes]	648.43 (antepartum) 648.44 (postpartum)

A provider may prescribe pharmacotherapy for smoking cessation for a client when the provider considers the treatment appropriate for the client. MAA covers pharmacotherapy for smoking cessation as follows:

- MAA covers Zyban® only;
- The product must be prescribed by a physician, ARNP, or PA;
- The client for whom the product is prescribed must be 18 years of age or older;
- The **pharmacy provider must obtain prior authorization** from MAA when filling the prescription for pharmacotherapy; and
- The provider must include both of the following on the client's prescription:

  - ✓ The client's estimated or actual delivery date; and
  - ✓ Notation that the client is participating in smoking cessation counseling.

To obtain prior authorization for Zyban®, pharmacy providers must call:

Drug Utilization and Review
1-800-848-2842

Smoking Cessation Intervention for Pregnant Clients

Step 1: ASK–1 minute

- Ask the client to choose the statement that best describes her smoking status:

A. I have NEVER smoked or have smoked LESS THAN 100 cigarettes in my lifetime. ☐

B. I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now. ☐

C. I stopped smoking AFTER I found out I was pregnant, and I am not smoking now. ☐

D. I smoke some now, but I have cut down on the number of cigarettes I smoke SINCE I found out I was pregnant. ☐

E. I smoke regularly now, about the same as BEFORE I found out I was pregnant. ☐

If the client stopped smoking before or after she found out she was pregnant (B or C), reinforce her decision to quit, congratulate her on success in quitting, and encourage her to stay smoke free throughout pregnancy and postpartum.

If client is still smoking (D or E), document smoking status in her medical record, and proceed to Advise, Assess, Assist, and Arrange.

Step 2: ADVISE–1 minute

- Provide clear, strong advice to quit with personalized messages about the benefits of quitting and the impact of smoking and quitting on the woman and fetus. ☐

Step 3: ASSESS-1 minute

- Assess the willingness of the client to attempt to quit within 30 days. ☐

If the client is ready to quit, proceed to Assist.
If the client is not ready, provide information to motivate the client to quit and proceed to Arrange.

Step 4: ASSIST-3 minutes +

- Suggest and encourage the use of problem-solving methods and skills for smoking cessation (eg, identify "trigger" solutions). ☐
- Provide social support as part of the treatment (e.g., "we can help you quit"). ☐
- Arrange social support in the smoker's environment (e.g., identify "quit buddy" and smoke-free space). ☐
- Provide pregnancy-specific, self-help smoking cessation materials. ☐

Step 5: ARRANGE-1 minute +

- Assess smoking status at subsequent prenatal visits and, if client continues to smoke, encourage cessation. ☐

Data from Melvin C. Dolan Mullen P, Windsor RA, Whiteside HP, Goldenberg RL. Recommended cessation counseling for pregnant women who smoke: a review of the evidence. Tobacco Control 2000; 9:1-5

Prenatal Management/Consultation & Referral

These definitions apply to the following tables labeled "Indications for Consultation & Referral":

Consultation **-** The process whereby the provider, who maintains primary management responsibility for the woman's care, seeks the advice or opinion of a physician on clinical issues that are patient-specific. These discussions may occur in person, by electronic communication, or by telephone. A consulting relationship may result in:

- Telephone, written, or electronic mail recommendations by the MD/DO;
- Co-management of the patient by both the midwife and the MD/DO;
- Referral of the patient to the MD/DO for examination and/or treatment;
- Transfer of care of the patient from the midwife to the MD/DO.

Referral **-** The process by which the provider directs the client to a physician (MD/DO) for management (examination and/or treatment) of a particular problem or aspect of the client's care.

Transfer of Care – The process by which the provider directs the client to a physician for complete management of the client's care.

The client must meet MAA's risk screening criteria in order to be covered for a planned home birth or a birth in a birthing center.

☞ **Note:** MAA expects the provider to screen out high-risk pregnancy following MAA risk screening guidelines. The following conditions may require either a consultation or referral. MAA expects the provider to use his or her professional judgment in assessing and determining appropriate consultation and need for referral in case of adverse situation. If a physician is the provider, he or she should consult with another physician as needed. Referrals to ARNPs are appropriate for treatment of simple infections.

Indications for Consultation and Referral

Antepartum

(Refers to the mother's care prior to the onset of labor)

Conditions Requiring Consultation

MAA requires physician (MD/DO) consultation and the client MAY require referral to a physician when the following conditions arise during the current pregnancy.

- Breech at 37 weeks;
- Polyhydramnios/Oligohydramnios;
- Significant vaginal bleeding;
- Persistent nausea and vomiting causing a weight loss of >15 lbs.;
- Post-dates pregnancy (>42 completed weeks);
- Fetal demise after 12 completed weeks gestation;
- Significant size/dates discrepancies;
- Abnormal fetal NST(non stress test);
- Abnormal ultrasound findings;
- Acute pyelonephritis;
- Infections, whose treatment is beyond the scope of the provider;
- Evidence of large uterine fibroid that may obstruct delivery or significant structural uterine abnormality;
- No prenatal care prior to the third trimester; or
- Other significant deviations from normal, as assessed by the provider.

Conditions Requiring Referral

MAA requires physician (MD/DO) consultation and referral when the following conditions arise during current pregnancy.

- Evidence of pregnancy induced hypertension (BP > 140/90 for more than 6 hours with client at rest);
- Hydatidiform mole (molar pregnancy);
- Gestational diabetes not controlled by diet;
- Severe anemia unresponsive to treatment (Hgb<10, Hct<28);
- Known fetal anomalies or conditions affected by site of birth;
- Noncompliance with the plan of care (e.g., frequent missed prenatal visits);
- Documented placental abnormalities, significant abruption past the 1st trimester, or any evidence of previa in the 3rd trimester;
- Rupture of membranes before the completion of 37 weeks gestation;
- Positive HIV antibody test;
- Documented IUGR (intrauterine growth retardation)
- Primary genital herpes past the 1st trimester; or
- Development of any of the high-risk conditions that are listed on page C.2.

Intrapartum

(Refers to the mother's care any time after the onset of labor,
up to and including the delivery of the placenta)

Conditions Requiring Consultation

MAA requires physician consultation and the client MAY require referral to a physician and/or hospital when the following maternal conditions arise intrapartum.

- Prolonged rupture of membranes (>24 hours and not in active labor); or
- Other significant deviations from normal as assessed by the provider.

Conditions Requiring Referral

MAA requires physician consultation and referral to a physician and/or hospital when the following conditions arise intrapartum.

Note: *In some intrapartum situations, due to time urgency, it may not be prudent to pause medical treatment long enough to seek physician consultation or initiate transport.*

- Labor before the completion of 37 weeks gestation, with known dates;
- Abnormal presentation or lie at time of delivery, including breech;
- Maternal desire for pain medication, consultation or referral;
- *Persistent non-reassuring fetal heart rate;
- Active genital herpes at the onset of labor;
- Thick meconium stained fluid with delivery not imminent;
- *Prolapse of the umbilical cord;
- Sustained maternal fever;
- *Maternal seizure;
- Abnormal bleeding (*hemorrhage requires emergent transfer);
- Hypertension with or without additional signs or symptoms of pre-eclampsia;
- Prolonged failure to progress in active labor; or
- *Sustained maternal vital sign instability and/or shock.

*** These conditions require emergency transport.**

Postpartum

(Refers to the mother's care in the first 24 hours following the delivery of the placenta)

Conditions Requiring Consultation

MAA requires physician consultation and the client MAY require referral to a physician when the following maternal conditions arise postpartum.

- Development of any of the applicable conditions listed under Antepartum and/or Intrapartum;
- Significant maternal confusion or disorientation; or
- Other significant deviations from normal as assessed by the provider.

Conditions Requiring Referral

MAA requires physician consultation and referral when the following conditions arise postpartum.

- *Anaphylaxis or shock;
- Undelivered adhered or retained placenta with or without bleeding;
- *Significant hemorrhage not responsive to treatment;
- *Maternal seizure;
- Lacerations, if repair is beyond provider's level of expertise (3^{rd} or 4^{th} degree);
- *Sustained maternal vital sign instability and/or shock;
- Development of maternal fever, signs/symptoms of infection or sepsis;
- *Acute respiratory distress; or
- *Uterine prolapse or inversion.

*** These conditions require emergency transport.**

Newborn

(Refers to the infant's care during the first 24 hours following birth)

Conditions Requiring Consultation

MAA requires a pediatric physician be consulted. The client MAY require a referral to an appropriate pediatric physician when the following conditions arise in a neonate.

- Apgar score ≤ 6 at five minutes of age;
- Birth weight <2500 grams;
- Abnormal jaundice; or
- Other significant deviations from normal as assessed by the provider.

Conditions Requiring Referral

MAA requires that a pediatric physician be consulted and a referral made when the following conditions arise in a neonate.

- Birth weight <2000 grams;
- *Persistent respiratory distress;
- *Persistent cardiac abnormalities or irregularities;
- *Persistent central cyanosis or pallor;
- Prolonged temperature instability when intervention has failed;
- *Prolonged glycemic instability;
- *Neonatal seizure;
- Clinical evidence of prematurity (gestational age <35 weeks);
- Loss of >10% of birth weight /failure to thrive;
- Birth injury requiring medical attention;
- Major apparent congenital anomalies; or
- Jaundice prior to 24 hours.

*** These conditions require emergency transport.**

Billing

Global (Total) Obstetrical Care

Global OB care (CPT codes 59400) includes:

- Routine antepartum care in any trimester;
- Delivery; and
- Postpartum care.

If you provide all of the client's antepartum care, perform the delivery, and provide the postpartum care, **you must bill** using the global OB procedure code.

> Bill the global obstetric procedure code if you performed all of the services and no other provider is billing for antepartum care, the delivery, or postpartum care. [Refer to WAC 388-533-0400(5)]. If a provider provides all or part of the antepartum care and/or postpartum care but does not perform the delivery, the provider must bill MAA for only those services provided using the appropriate antepartum and/or postpartum codes. In addition, if the client obtains other medical coverage or is transferred to an MAA managed care plan during her pregnancy, the provider must bill for only those services provided while the client is enrolled with MAA fee-for-service.

Unbundling Obstetrical Care

In the situations described below, you may not be able to bill MAA for global OB care. In these cases, it may be necessary to "unbundle" the OB services and bill the antepartum, delivery, and postpartum care separately, as MAA may have paid another provider for some of the client's OB care, or you may have been paid by another insurance carrier for some of the client's OB care.

When a client transfers to your practice late in the pregnancy…

- If the client has had antepartum care elsewhere, you will not be able to bill the global OB package. Bill the antepartum care, delivery, and postpartum care separately. The provider who had been providing the antepartum care prior to the transfer bills for the services that he/she performed. Therefore, if you bill the global OB package, you would be billing for some antepartum care that another provider has claimed.

- Or -

- If the client did not receive any antepartum care prior to coming to your office, bill the global OB package.

  In this case, you may actually perform all of the components of the global OB package in a short time. MAA does not require you to perform a specific number of antepartum visits in order to bill for the global OB package.

If your client moves to another provider (not associated with your practice), moves out of your area prior to delivery, or loses the pregnancy…

Bill only those services you actually provide to the client.

If your client changes insurance during her pregnancy…

Often, a client will be fee-for-service at the beginning of her pregnancy, and then be enrolled in an MAA managed care plan for the remainder of her pregnancy. MAA is responsible for reimbursing only those services provided to the client while she is on fee-for-service. The managed care plan reimburses for services provided after the client is enrolled with the plan.

When a client changes from one plan to another, bill those services that were provided while she was enrolled with the original plan to the original carrier, and those services that were provided under the new coverage to the new plan. You must unbundle the services and bill the antepartum, delivery, and postpartum care separately.

Routine Antepartum Care

Antepartum care includes:

- Initial and subsequent history;
- Physical examination;
- Recording of weight and blood pressure;
- Recording of fetal heart tones;
- Routine chemical urinalysis; and
- Maternity counseling, such as risk factor assessment and referrals.

Necessary prenatal laboratory tests may be billed in addition to antepartum care, **except for dipstick tests** (CPT codes 81000, 81002, 81003, and 81007).

Per CPT guidelines, MAA considers routine antepartum care for a normal, uncomplicated pregnancy to consist of:

- Monthly visits up to 28 weeks gestation;
- Biweekly visits to 36 weeks gestation; and
- Weekly visits until delivery;
  (approximately 14 antepartum visits). See chart below for billing.

Procedure Code/ Modifier	Description	Limitations
59426	Antepartum care, 7 or more visits	Limited to one unit per client, per pregnancy.
59425	Antepartum care, 4-6 visits	Limited to one unit per client, per provider per pregnancy.
99211-99215 TH	Office visits, antepartum care 1-3 visits only, w/obstetrical service modifier	Diagnoses V22.0-V22.2 limited to 3 units; must use modifier TH with diagnoses to be reimbursed.

☞ **Note: Do not bill** CPT codes 59425, 59426, and E&M codes 99211-99215 with normal pregnancy diagnoses in combination with each other during the same pregnancy. **Do not bill MAA for antepartum care until all antepartum services are complete.**

When an eligible client receives services from more than one provider, MAA reimburses each provider for the services furnished.
[Refer to WAC 388-533-0400(7)]

Example: For a client being seen by both a midwife and a physician, MAA's reimbursement for the co-management of the client would be as follows:

- ✓ The physician would be paid for the consult office visits; and
- ✓ The midwife would be paid for the antepartum visits.

Coding for Antepartum Care Only

If it is necessary to unbundle the global package and bill separately for antepartum care, bill **one** of the following:

- If the client had a **total** of one to three antepartum visits, bill the appropriate level of **E&M service with modifier TH** for each visit, with the date of service the visit occurred and the appropriate diagnosis; **Or**

> **Modifier TH**: Obstetrical treatment/service, prenatal or postpartum

- If the client had a **total** of four to six antepartum visits, bill using **CPT code 59425** with a "1" in the units box. Bill MAA using the date of the last antepartum visit in the "to and from" fields; **Or**

- If the client had a **total** of seven or more visits, bill using **CPT code 59426** with a "1" in the units box. Bill MAA using the date of the last antepartum visit in the "to and from" fields.

Do not bill antepartum care only codes in addition to any other procedure codes that include antepartum care (i.e. global OB codes).

When billing for antepartum care, **do not bill** using CPT E&M codes for the first three visits, then CPT code 59425 for visits four through six, and then CPT code 59426 for visits seven and on. These CPT codes are used to bill only the **total** number of times you saw the client for all antepartum care during her pregnancy, and **may not** be billed in combination with each other during the entire pregnancy period.

> ☞ **Note: Do not** bill MAA until all antepartum services are complete.

Coding for Deliveries

If it is necessary to unbundle the global OB package and bill for the delivery only, you must bill MAA using the vaginal delivery only code (CPT code 59409).

If you do not provide antepartum care, but perform the delivery and provide postpartum care, bill MAA using the vaginal delivery, including postpartum care code (CPT code 59410).

Coding for Postpartum Care Only

If it is necessary to unbundle the global OB package and bill for postpartum care only, you must bill MAA using CPT code 59430 (postpartum care only).

If you provide all of the antepartum and postpartum care, but do not perform the delivery, bill MAA for the antepartum care using the appropriate coding for antepartum care (see page D.4), along with CPT code 59430 (postpartum care only).

Do not bill CPT code 59430 (postpartum care only) in addition to any procedure codes that include postpartum care.

> ☞ **Note:** Postpartum care includes office visits for the six week period after the delivery and includes family planning counseling.

Increased Monitoring

When providing **increased monitoring** for the conditions listed below in excess of the CPT guidelines for normal antepartum visits, bill using E&M **codes 99211-99215 with modifier TH.** The office visits may be billed in addition to the global fee **only after** exceeding the CPT guidelines for normal antepartum care (i.e., monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery).

Procedure Code/ Modifier	Summary of Description	Limits
99211–99215 TH	Office visits; use for increased monitoring prenatal management	Limited to diagnoses: 640.03, 642.03, 642.33, 643.03, 644.03, 648.23, 648.83. Must have – TH to pay midwives.

If the client has one of the conditions listed above, the provider is not automatically entitled to additional payment. Per CPT guidelines, it must be medically necessary to see the client **more often** than what is considered routine antepartum care in order to qualify for additional payments. **The additional payments are intended to cover additional costs incurred by the provider as a result of more frequent visits.**

> ☞ **Note:** Licensed midwives are limited to billing for certain medical conditions (see pages C.1 – C.2) that require additional monitoring under this program.

For example:

> Client A is scheduled to see her provider for her antepartum visits on January 4, February 5, March 3, and April 7. The client attends her January and February visits, as scheduled. However, during her scheduled February visit, the provider discovers the client's blood pressure is slightly high and wants her to come in on February 12 to be checked again. At the February 12 visit, the provider discovers her blood pressure is still slightly high and asks to see her again on February 18. The February 12 and February 18 visits are outside of her regularly scheduled antepartum visits, and outside of the CPT guidelines for routine antepartum care since she is being seen more often than once per month. The February 12 and February 18 visits may be billed separately from the global antepartum visits using the appropriate E&M codes with modifier TH, and the diagnosis must represent the medical necessity for billing additional visits. **A normal pregnancy diagnosis (i.e. V22.0 – V22.2) will be denied outside of the global antepartum care**. *It is not necessary to wait until all services included in the routine antepartum care are performed to bill the extra visits, as long as the extra visits are outside of the regularly scheduled visits.*

Labor Management

Providers may bill for labor management **only** when another provider (outside of your group practice) performs the delivery. If you performed all of the client's antepartum care, attended the client during labor, delivered the baby, and performed the postpartum care, **do not** bill MAA for labor management. These services are included in the global OB package.

However, if you performed all of the client's antepartum care and attended the client during labor, but transferred the client to another provider (outside of your group practice) for delivery, you must unbundle the global OB package and bill separately for antepartum care and the time spent managing the client's labor. The client must be in active labor when the referral to the delivering provider is made.

To bill for labor management in the situation described above, bill MAA for the time spent attending the client's labor using the appropriate CPT E&M **codes 99211-99215 with modifier TH** (for labor attended in the office) **or 99347-99350** (for labor attended at the client's home). In addition, MAA will reimburse providers for **up to three hours** of labor management using prolonged services CPT **codes 99354-99355 with modifier TH**. Reimbursement for prolonged services is *limited to three hours per client, per pregnancy*, regardless of the number of calendar days a client is in labor, or the number of providers who provide labor management. **Labor management may not be billed by the delivering provider, or by any provider within the delivering provider's group practice**.

☞ **Note**: The E&M code and the prolonged services code(s) **must** be billed on the same claim form.

Procedure Code/ Modifier	Summary of Description	Limits
99211-99215 TH **or**	Office visits – labor at birthing center	Diagnoses 640–674.9; V22.0–V22.2; and V23–V23.9; must have modifier TH to be reimbursed with these diagnoses; labor management may not be billed by delivering physician.
99347-99350 TH	Home visits – labor at home	
+99354 TH **Limited to 1 unit**	Prolonged services, 1st hour	
+99355 TH **Limited to 4 units**	Prolonged services, each add'l 30 minutes	

Department of Health (DOH) Newborn Screening Tests

A midwife or physician may bill MAA for reimbursement of procedure code S3620 after paying the Department of Health for the cost of the newborn screening tests for metabolic disorders. The newborn screening panel includes screens for:

- PKU;
- CAH;
- Congenital hypothyroidism;
- Hemoglobinopathies;
- Biotinidase deficiency;
- MSUD;
- MCAD deficiency;
- Homocystinuria; and,
- Galactosemisa.

☞ **Note**: Reimbursement includes two tests for two different dates of service, **allowed once per newborn**. Do not bill procedure code S3620 if the baby is born in the hospital because the hospital has been charged for the tests.

Immunizations

Immunization administration CPT codes 90471 and 90472 may be billed only when the materials are not received free of charge from DOH. For information on Immunizations, please refer to MAA's *Physician-Related Services Billing Instructions* or *EPSDT Billing Instructions.*

You may view these billings instructions online at http://maa.dshs.wa.gov (select the *Billing Instructions/Numbered Memoranda* link).

Home Birth Kit

When disposable items are used, bill MAA for a home birth kit using HCPCS code S8415. Reimbursement is **limited to one per client, per pregnancy.**

Procedure Code	Summary of Description	Limits
S8415	Supplies for home delivery of infant	Limited to one per client, per pregnancy.

Medications

Certain medications can be billed separately and are listed on the fee schedule. Some of the medications listed in MAA's fee schedule are not billable by Licensed Midwives. By law, a licensed midwife may obtain and administer only certain medications. Drugs listed as "not billable by a licensed midwife" must be obtained at a pharmacy with a physician order. If you are unable to obtain a medication from a pharmacy and are using from your own supply, **see Section E - Authorization** for further information on billing.

☞ **Note**: Drugs must be billed using the procedure codes listed in the fee schedule and are reimbursed at MAA's established maximum allowable fees. Name, strength, and dosage of the drug must be documented and retained in the client's file for review.

Newborn Assessment

To bill for a newborn assessment completed at the time of the home birth, providers must bill using CPT code 99432. Reimbursement is **limited to one per newborn.** Do not bill CPT code 99432 if the baby is born in a hospital. Bill on a separate claim form and in field 19 enter "B" for baby under mother's PIC.

Billing - Specific to Birthing Centers (Facility Fees)

For births with dates of service on and after January 1, 2005.

☞ **Note:** The midwife must bill MAA for the facility fee or facility transfer fee payment. MAA pays the midwife, who then reimburses the approved birthing center. See Important Contacts for a list of approved birthing centers.

Facility Fee – When billing for the facility fee, use CPT code 59409 with modifier SU. Only a facility licensed as a childbirth center by DOH and approved by MAA is eligible for a facility fee. Bill this fee only when the baby is born in the facility. The facility fee includes all room charges for mother and baby, equipment, supplies, anesthesia administration, and pain medication. The facility fee does not include other drugs, professional services, lab charges, ultrasound, other x-rays, blood draws, or injections.

Facility Transfer Fee – The facility transfer fee may be billed when the mother is transferred in active labor to a hospital for delivery there. Use CPT code S4005 when billing for the facility transfer fee.

Procedure Code/ Modifier	Summary of Description	Limits
59409 SU	Delivery only code with use of provider's facility or equipment modifier.	Limited to one per client, per pregnancy.
S4005	Interim labor facility global (labor occurring but not resulting in delivery)	Limited to one per client, per pregnancy; may only be billed when client labors in the birthing center and then transfers to a hospital for delivery.

☞ **Note:** Payments to midwives for facility use are limited to only those birthing centers that have been approved by MAA. When modifier SU is attached to the delivery code, it is used to report the use of the provider's facility or equipment only. The name of the birthing center must be entered in box 32 on the HCFA form.

Billing – General to all Medical Assistance Programs

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards for: 1) initial claims; and 2) resubmitted claims.

- **Initial Claims**

  - ✓ MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

    - The date the provider furnishes the service to the eligible client;
    - The date a final fair hearing decision is entered that impacts the particular claim;
    - The date a court orders MAA to cover the services; or
    - The date DSHS certifies a client eligible under delayed[1] certification criteria.

  - ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

    - DSHS certification of a client for a retroactive[2] period; or
    - The provider proves to MAA's satisfaction that there are extenuating circumstances.

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[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- **Resubmitted Claims**

  Providers may **resubmit, modify, or adjust** any timely initial claim, **except** prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

Note: MAA does not accept any claim for resubmission, modification, or adjustment after the time period listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA?

Bill MAA your usual and customary fee.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's DSHS Medical ID Card. An insurance carrier's time limit for claim submissions may be different. It is your responsibility to meet MAA's and the insurance carrier's requirements relating to billing time limits, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov/LTPR or by calling the Coordination of Benefits Section at 1-800-562-6136.

How do I bill for services provided to PCCM clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager name in field 17 on the HCFA-1500 claim form; and

- Enter the MAA seven-digit identification number of the Primary Care Case Managers (PCCM) who referred the client for the service(s). If the client is enrolled in a PCCM plan and the PCCM referral number is **not** in field 17a when you bill MAA, the claim will be denied.

What documentation must be kept in the client's record?

[Refer to WAC 388-533-0600]

Antepartum Care

- Initial general (Gen) history, physical examination, and prenatal lab tests.
- Gynecological (Gyn) history, including obstetrical history, physical examination, and standard lab tests. Ultrasound, if indicated.
- Subsequent Gen/Gyn history, physical and lab tests.
- Client's weight, blood pressure, fetal heart tones, fundal height, and fetal position at appropriate gestational age.
- Consultation, referrals, and reason for transferring care, if necessary.
- Health education and counseling.
- Consultation or actual evaluation by the consulting physician for any high-risk condition.
- Risk screening evaluation.

Intrapartum/Postpartum Care

- Labor, delivery, and postpartum periods.
- Maternal, fetal, and newborn well-being, including monitoring of vital signs, procedures, and lab tests.
- Any consultation referrals and reason for transferring care, if necessary.
- Initial pediatric care for newborn, including the name of the pediatric care provider, if known.
- Postpartum follow-up, including family planning.

Informed Consent

- Copy of informed consent, including all of the following:

  - ✓ Scope of maternal and infant care;
  - ✓ Description of services provided;
  - ✓ Limitations of technology and equipment in the home birth setting;
  - ✓ Authority to treat;
  - ✓ Plan for physician consultation or referral;
  - ✓ Emergency plan;
  - ✓ Informed assumption of risks; and
  - ✓ Client responsibilities.

General to all providers [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, **for at least six years from the date of service** or more if required by federal or state law or regulation.

National Correct Coding Initiative (CCI)

The Medical Assistance Administration (MAA) is evaluating and implementing Medicare's National Correct Coding Initiative (CCI). CCI changes could affect reimbursements to providers for CPT and HCPCS procedure codes.

CCI was created by the Centers for Medicare and Medicaid Services (CMS) to promote correct coding by physicians and providers and to ensure that appropriate payments are made for provider services. CCI coding policies are based on the following:

- The American Medical Association's (AMA) Current Procedural Terminology (CPT) manual;
- National and local policies and edits;
- Coding guidelines developed by national professional societies;
- Analysis and review of standard medical and surgical practices; and
- Review of current coding practices.

CCI coding policies do not supercede MAA's current Washington Administrative Code (WAC) regarding coverage and reimbursement policies or MAA Billing Instructions and Numbered Memoranda.

For more information, please see the National Correct Coding Initiative web site:

http://www.cms.hhs.gov/physicians/cciedits/

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Authorization

Expedited Prior Authorization (EPA)

What is the EPA process?

MAA's EPA process is designed to eliminate the need to request authorization from MAA. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an "EPA" number when appropriate.

When do I need to create an EPA number?

Drugs that are listed as "Not billable by a Licensed Midwife" in the fee schedule can be administered by licensed midwives when ordered by a physician. For licensed midwives to be reimbursed by MAA for the administration of these drugs, the licensed midwife must meet the EPA criteria listed below.

How do I create an EPA number?

Once the EPA criteria are met, the licensed midwife must create a 9-digit EPA number.
The first six digits of the EPA number must be 870000**.**
The last 3 digits must be **690**, which meets the EPA criteria listed below.

> ☞ **Note:** Licensed midwives are reminded that this EPA number is ONLY for the procedure codes listed in the fee schedule as "Not billable by a Licensed Midwife."

EPA Criteria for Drugs "Not Billable by Licensed Midwives"
Procedure Codes: 90371, J2540, S0077, J0290, J1364

690 Licensed midwife has met all of the following:

- Obtained physician or standing orders for the administration of the drug(s) listed as "not billable by a licensed midwife;"
- The physician or standing orders are located in the client's file; and
- The licensed midwife will provide a copy of the physician or standing orders to MAA upon request.

> ☞ **Note – Billing:** Enter the EPA number (**870000690**) in field 23 (Prior Authorization) on the HCFA-1500 claim form.
> **Do not handwrite the EPA number onto the claim.** (See Section G – *How to Complete the HCFA-1500 Claim Form.*)

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Fee Schedule

Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief CPT procedure code descriptions. To view the entire description, please refer to your current CPT book.

Use the following procedure codes when billing for Birthing Center services:

Routine Antepartum Care			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/05**
☞ **Note:** CPT codes 59425, 59426, or E&M codes 99211-99215 with normal pregnancy diagnoses V22.0-V22.2, **may not** be billed in combination during the entire pregnancy. **Do not bill MAA for antepartum care until all routine antepartum services are complete.**			
59425		Antepartum care, 4-6 visits. **Limited to 1 unit per client, per pregnancy, per provider.**	$450.35
59426		Antepartum care, 7 or more visits. **Limited to 1 unit per client, per pregnancy, per provider.**	790.02
99211	TH	Office visits, antepartum care 1-3 visits, w/obstetrical service modifier. **99211 – 99215 limited to 3 units total, per pregnancy, per provider.** Must use modifier TH when billing.	14.40
99212	TH	Office/outpatient visit, est	25.56
99213	TH	Office/outpatient visit, est	34.75
99214	TH	Office/outpatient visit, est	54.36
99215	TH	Office/outpatient visit, est	78.93

Additional Monitoring

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/05
☞ **Note:** Midwives who provide increased monitoring for the diagnoses listed on page C.1 and C.2 and are seen in excess of the CPT guidelines for routine antepartum care may bill using the appropriate E&M code with modifier TH.			
99211	TH	Office/outpatient visit, est	$14.40
99212	TH	Office/outpatient visit, est	25.56
99213	TH	Office/outpatient visit, est	34.75
99214	TH	Office/outpatient visit, est	54.36
99215	TH	Office/outpatient visit, est	78.93

Delivery (Intrapartum)

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/05
59400		Obstetrical care [prenatal, delivery, and postpartum care]	$1940.02
59409		Obstetrical care [delivery only]	967.73
59410		Obstetrical care [delivery and postpartum only]	1082.46

Postpartum

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/05
59430		Care after delivery [postpartum only]	$170.96

Labor Management

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/05
☞	**Note:** Bill only when the client labors at the birthing center or at home and is then transferred to a hospital, another provider delivers the baby, and a referral is made during active labor. The following diagnoses must be used 640–674.9; V22.0–V22.2; and V23–V23.9.		
☞	**Note:** Labor management may not be billed by the delivering physician. Prolonged services must be billed **on the same claim form** as E&M codes along with modifier TH and one of the diagnoses listed above (all must be on each detail line of the claim form).		
Use when client labors at birthing center			
99211	TH	Office/outpatient visit, est (Use when client labors at birthing center)	$14.40
99212	TH	Office/outpatient visit, est	25.56
99213	TH	Office/outpatient visit, est	34.75
99214	TH	Office/outpatient visit, est	54.36
99215	TH	Office/outpatient visit, est	78.93
OR - Use when client labors at home			
99347	TH	Home visit, est patient	27.25
99348	TH	Home visit, est patient	43.15
99349	TH	Home visit, est patient	66.77
99350	TH	Home visit, est patient	98.79
And			
+ 99354 (Add-on code)	TH	Prolonged services, 1st hour. **Limited to 1 unit.**	59.50
+ 99355 (Add-on code)	TH	Prolonged services, each add'l 30 minutes. **Limited to 4 units.**	59.05

Other			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/05**
59020		Fetal contract stress test	$37.93
59020	TC	Fetal contract stress test	13.85
59020	26	Fetal contract stress test	24.07
59025		Fetal non-stress test	49.04
59025	TC	Fetal non-stress test	11.25
59025	26	Fetal non-stress test	37.79
36415		Drawing blood	2.46
84703		Chorionic gonadotropin assay	8.60
85013		Hematocrit	2.71
85014		Hematocrit	2.71
A4266		Diaphragm	33.92
A4261		Cervical cap for contraceptive use	47.00
57170		Fitting of diaphragm/cap	57.00
90782		Injection, sc/im	11.36
90371		Hep b ig, im **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	117.74
J2790		Rh immune globulin	93.54
J2540		Injection, penicillin G potassium, up to 600,000 units. **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	1.35
S0077		Injection, clindamycin phosphate, 300 mg. **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	Acquisition Cost

Other (cont.)			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/05**
J0290		Injection, ampicillin, sodium, up to 500mg. (use separate line for each 500 mg used) **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	$2.21
J1364		Injection, erythromycin lactobionate, per 500 mg. (use separate line for each 500 mg used) **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	2.91
J7050		Infusion, normal saline solution, 250cc	.26
S5011		5% dextrose in lactated ringer, 1000 ml.	Acquisition Cost
J7120		Ringers lactate infusion, up to 1000cc	.93
J2210		Injection methylergonovine maleate, up to 0.2mg	4.31
J3475		Injection, magnesium sulfate, per 500 mg	.12
J2590		Injection, oxytocin	1.13
J0170		Injection adrenalin, epinephrine, up to 1ml ampule	.61
J3430		Injection, phytonadione (Vitamin K) per 1 mg.	2.37
90708		Measles-rubella vaccine, sc	18.22
90471		Immunization admin	5.05
90472		Immunization admin, each add **[List separately in addition to code for primary procedure.]**	3.03

Other (cont.)			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/05**
S3620		Newborn metabolic screening panel, include test kit, postage and the laboratory tests specified by the state for inclusion in this panel. **[Department of Health newborn screening tests for metabolic disorders. Includes 2 tests on separate dates; one per newborn.]**	$64.40
99401		Preventive counseling, indiv [approximately 15 minutes] Restricted to diagnoses: 648.43 (antepartum) and 648.44 (postpartum) **[For Smoking Cessation only]**	25.44
99402		Preventive counseling, indiv [approximately 30 minutes] Restricted to diagnoses: 648.43 (antepartum) and 648.44 (postpartum) **[For Smoking Cessation only]**	42.69
99432		Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s). **Limited to one per newborn. Do not bill MAA if baby is born in a hospital.**	78.45
99440		Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output	90.39
92950		Cardiopulmonary resuscitation (e.g., in cardiac arrest)	188.27

Fee Schedule for Facility Fee Payment

MAA reimburses for a facility fee only when services are performed in Birthing Centers licensed by the Department of Health that have a Core Provider Agreement with MAA. The facility payments listed below will be billed by and paid to the midwife who must then reimburse the birthing center.

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/05
59409	SU	Delivery only code with use of provider's facility or equipment modifier. **Limited to one unit per client, per pregnancy.** Facility fee includes all room charges, equipment, supplies, anesthesia administration, and pain medication.	$733.16
S4005		Interim labor facility global (labor occurring but not resulting in delivery). **Limited to one per client, per pregnancy.** May only be billed when client labors in the birthing center and then transfers to a hospital for delivery.	366.68

☞ **Note:** Payments for facility use are limited to only those providers who have been approved by MAA. When modifier SU is attached to the delivery code, it is used to report the use of the provider's facility or equipment only.

Fee Schedule for Home Birth Supplies

Home Birth Kit

Procedure Code	Summary of Description	Maximum Allowable Fee 7/1/05
S8415	Supplies for home delivery of infant **Limited to one per client, per pregnancy.**	$45.00

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How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Failure to comply with the following instructions may result in the claim being denied or suspended. Either of these actions will extend the time period between claims submission and final adjudication.

Important!

Guidelines/Instructions:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner **cannot read** black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

  - **Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" or similar statements on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field	Description/Instructions

1A. **Insured's ID No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the client's DSHS Medical ID Card. This number consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder **before** adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.
- Tom O'Malley's PIC should look like this: TC020652O'MALA (**Note:** Always use the exact PIC as it appears on the client's Medical ID Card regardless of whether it follows the above examples.)

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, and private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, Healthy Options, First Steps, Medicare, Public Assistance, etc., are **inappropriate** entries for this field.

Field	Description/Instructions
10.	**Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24.* ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).
11.	**Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4.* Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.
11a.	**Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3.*
11b.	**Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.
11c.	**Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

Field	Description/Instructions
11d.	**Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.
17.	**Name of Referring Physician or Other Source**: When applicable, enter the primary physician.
17a.	**ID Number of Referring Physician**: When applicable, enter the 7-digit MAA-assigned primary physician number.
19.	When applicable. When billing for baby using the parent's PIC, **enter "B."**
21.	**Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.
22.	**Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the *Remittance and Status Report*.)

Field	Description/Instructions
23.	**Prior Authorization Number**: To be reimbursed for drugs listed in fee schedule as "Not billable by a Licensed Midwife**," enter the EPA number 870000690**. (See Section E for further information.)
24.	**Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.
24A.	**Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 05, 2003 = 070503).
24B.	**Place of Service**: Required. 11 Office 12 Home 25 Birthing Center
24C.	**Type of Service**: Required prior to October 1, 2003, dates of service. Enter a 3 for all services billed. **For claims with dates of service on and after October 1, 2003, this field IS NOT A REQUIRED FIELD.**
24D.	**Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate Current Procedural Terminology (CPT) or HCFA Common Procedure Coding System (HCPCS) for the services being billed. **Modifier**: When appropriate enter a modifier.

Field	Description/Instructions
24E.	**Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.
24F.	**$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.
24G.	**Days or Units**: Required. Enter the total number of units for each line. These figures must be whole units.
25.	**Federal Tax ID Number: Leave this field blank.**
26.	**Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your *Remittance and Status Report* under the heading *Patient Account Number*.
28.	**Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

Field	Description/Instructions

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

32. **Name and Address of Facility Where Services Were Rendered**: Enter the name of the birthing center.

33. **Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

P.I.N.: This is the seven-digit number assigned to you by MAA for:

A) An individual practitioner (solo practice); **or**

B) An identification number for individuals only when they are part of a group practice (see below).

Group: This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.

Note: Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

Providers in Birthing Centers

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): MK070174SMITHA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, MARY K

3. PATIENT'S BIRTH DATE MM DD YY: 07 01 74 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1800 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): (360) 111-2222

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V22.2
2. 650.
3. 643.03
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 01 05	02 01 05	25	3	59410		2	105637	1				
2 07 01 04	07 01 04	11	3	99211	TH	3	1425	1				
3 01 31 05	01 31 05	11	3	59425		1	44238	1				
4 02 01 05	02 01 05	25	3	59409	SU	2	73316	1				
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. $ TOTAL CHARGE: 224616

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 224616

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

ABC BIRTH CENTER
103 MAIN STREET
ANYTOWN WA 98300

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

MARY SMITH LM 105 STATE STREET
ANYTOWN WA 98000 (360) 555-1111

PIN# GRP# 7000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

Billing Home Birth

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): MK070174SMITHA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, MARY K

3. PATIENT'S BIRTH DATE MM DD YY: 07 01 74 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1800 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): (360) 111-2222

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V22.2
2. 650
3. V27.0
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	03	04	05	03	04	05	12	3	59400		2,3	189978	1				
2	03	04	05	03	04	05	12	3	S8415		2	4500	1				
3																	
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. $ TOTAL CHARGE: 194478

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 194478

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

TONI ANDERSON, LM 123 8TH AVENUE
ANYTOWN WA 98000

PIN# GRP# 7090000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

Billing Baby's Care - Home Birth

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): CC100182JONESA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): JONES, JENNY E

3. PATIENT'S BIRTH DATE: MM 03 DD 02 YY 05 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): JONES, CATHY C

5. PATIENT'S ADDRESS (No., Street): 100 SPRING STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 98500 TELEPHONE (Include Area Code): (360) 325-1000

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: B (INDICATES BABY UNDER MOTHER'S PIC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V30.2
2. _____
3. _____
4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03	02	05	03	02	05	12	3	99432		1	7638	1				
2 03	02	05	03	02	05	12	3	S3620		1	6440	1				
3 03	02	05	03	02	05	12	3	36415		1	245	1				
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. $ TOTAL CHARGE: 14323

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 14323

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

MARY SMITH 100 AVENUE W
SEATTLE WA 98100 (206) 525-0000

PIN# GRP# 7005000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500